

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 2, Issue 10

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How Do “No Harm” Violations Impact Nursing Home Quality & Safety?

Nursing homes that voluntarily participate in the Medicare and Medicaid programs must adhere to minimum standards of care established by the federal Nursing Home Reform Law and its implementing regulations. These standards ensure that nursing home residents are provided services that help them attain or maintain their “highest practicable physical, mental, and psychosocial well-being.” Nursing homes that fail to meet the federal requirements are subject to various penalties, based on the scope and severity of the violation(s).

Unfortunately, the overwhelming majority of health violations in nursing homes are cited as causing “no harm” to residents. The failure to recognize resident pain, suffering, and humiliation when it occurs too often means nursing homes are not held accountable for violations through financial penalties. In the absence of a financial penalty, nursing homes may have little incentive to correct the underlying causes of substandard nursing home quality and safety.

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How to Use this Newsletter

The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS’s [Nursing Home Compare](#) website. **Our organizations encourage residents, families, ombudsmen, law enforcement, and others to use these cases to help identify potential instances of resident harm in their own communities.** While CMS may fail to properly penalize nursing homes for health violations, it is important that the public is aware of nursing home safety concerns in their communities and that every suspected case of resident harm is reported, investigated, and addressed.

Elizabeth Church Manor Nursing Home (New York)

Five-star facility fails to keep food within safe temperature ranges.

The surveyor determined that the nursing home failed to “provide food and drink that was palatable, attractive, and at a safe and appetizing temperature for 2 of 2 meal trays . . . tested for palatability and temperature.”¹ Although meals were not within a safe temperature range, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- During the dining service at 5:46 P.M., food from the steam tables were plated and served to residents. A resident was served his meal at 6:05 P.M. in his room. In the presence of the food service director, the surveyor obtained the temperatures of the food.
- According to the surveyor’s thermometer, the ham salad was 66 degrees; the facility’s thermometer registered the item at 58 degrees. The tapioca pudding was registered at 55 degrees using both thermometers.
- The food service director acknowledged that “19 minutes was not an acceptable length of time to get food from the steam table to residents in their rooms. Trays should be passed in a timely manner to keep holding food at required minimum/maximum temperature requirements.” He added that “the ham salad temperature of 66 degrees F was not acceptable.”
- **Note:** Foodborne illnesses pose a significant risk to vulnerable nursing home residents. However, in 2019, CMS issued a proposed rule rolling back the qualifications for directors of food and nutrition services. To read our joint comments opposing the proposed change, please visit [LTCCC’s Comments and Statements page](#).

→ **Every facility must treat residents with respect and dignity. Each resident has the right to a dignified existence and self-determination.**

→ **Every resident has the right to be free from abuse, neglect, misappropriation of property, and exploitation.**

Good Samaritan Society – Albert Lea (Minnesota)

Five-star nursing home fails to inform a resident of medication change which resulted in unnecessary pain.

The surveyor determined that the nursing home failed to notify a resident “of changes prior to discontinuing a medication.”² Although this failure resulted in the resident experiencing “severe pain,” the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- A resident with an indwelling catheter, who received medications to treat enlargement of the prostate and for obstructive and reflex issues experienced penile pain and “voiced concerns over having his bladder medication having been stopped previously without his knowledge.” In fact, his medication had been stopped again without his knowledge or consent. Once the medication was restarted, the pain went away.
- The resident indicated he was upset that he was not included on the decision to discontinue the medication and subsequent notification related to changes in his care.
- A review of the nurse progress notes indicated that the resident experienced “severe pain- penis hurts- awake most of the night shift” and the primary care physician’s notes stated that “[w]e recently tried stopping his [medicine]; however, he noted significant increase in bladder pain when off that medication. He is otherwise feeling well now that we have started that medication again.”

- Though the facility's policy is to immediately inform the resident when there is a need to discontinue or change an existing form of treatment or to commence a new form of treatment, facility staff were unable to find documentation indicating that the resident or his daughter had been informed of the change.
- **Note:** Every nursing home resident has the right be informed of and participate in his or her treatment, including the right to be informed of changes to care in advance. To learn more, please read LTCCC's [Informed Consent](#) fact sheet.

Woodhaven Nursing Home (New York)

One-star nursing home fails to ensure a resident was free from chemical restraints.

The surveyor determined that the nursing home "did not ensure that each resident's drug regimen was free from chemical restraints."³ Although the resident was being chemically restrained, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- A nursing progress note documented that the resident was "resisting care and appeared timid at times." The psychiatrist was contacted and daily medication was ordered for the resident's behavior during activities of daily living (ADL) care.
- A licensed practical nurse (LPN) reviewed the resident's medical record with the surveyor. The LPN acknowledged that "there was no documented evidence an assessment was completed to determine a cause for the resident's resistive and timid behavior prior to initiation" of the medication.
- A certified nursing assistant (CNA) told the surveyor that the resident had been "resistive to care in the shower and sometimes when you wash him in bed, but, if you explain the care you are providing to him the resident reacts better."
- **Note:** Every resident has the right to be free from physical and chemical restraints imposed to discipline the resident or for the convenience of staff. To learn more, please visit [LTCCC's fact sheet](#).

→ **Every facility must ensure residents can exercise their rights as nursing home residents and citizens/residents of the United States without interference, coercion, discrimination, or reprisal from the facility.**

Walker Rehabilitation Center, Inc. (Alabama)

Two-star nursing home fails to properly turn and reposition a resident with a pressure ulcer.

The surveyor determined that the nursing home failed to ensure that a resident, who was bedbound and had a pressure ulcer, was repositioned every two hours.⁴ Despite this failure, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- The resident had a stage 4 pressure ulcer on his coccyx. The care plan called for turning and repositioning every 2 hours and as needed. During resident observations, the surveyor witnessed the resident lying on his back over the course of several hours. The resident told the surveyor that he had not been repositioned that day and staff only turned him "sometimes."
- A certified nursing assistant (CNA) told the surveyor that the resident's pressure ulcer "could get worse" because of "the potential harm of not turning a resident who has a pressure ulcer to the coccyx." The director of nurses acknowledged that the resident was bedbound and had a pressure ulcer on his coccyx, agreeing with the CNA that failing to reposition a resident could make the pressure ulcer worse.

- **Note:** Every resident with a pressure ulcer must receive care to promote healing, prevent infection, and prevent new pressure ulcers. Residents without pressure ulcers must receive care to prevent pressure ulcers from developing, unless medically unavoidable. To learn more, please see [LTCCC's fact sheet](#).

Can I Report Resident Harm?

YES! Residents and families should not wait for annual health inspections to detect resident harm. Anyone can report violations of the nursing home standards of care by contacting their state survey agency. To file a complaint against a nursing home, please use [this resource](#) available at CMS's Nursing Home Compare website. If you do not receive an adequate or appropriate response, [contact your CMS Regional Office](#).



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To learn more about nursing home and assisted living care, visit us online at
[MedicareAdvocacy.org](#) & [NursingHome411.org](#).

Note: The overall star rating of any facility identified in this newsletter is subject to change. The star ratings are current as of the date of newsletter's drafting.

Note: This document is the work of the LTCCC. It does not necessarily reflect the views of the Department of Health, nor has the Department verified the accuracy of its content.

¹ Statement of Deficiencies for Elizabeth Church Manor Nursing Home (Jan. 16, 2020), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335090&SURVEYDATE=01/16/2020&INSPTYPE=STD&profTab=1&Distn=6874.4&state=NY&lat=0&lng=0&name=ELIZABETH%20CHURCH%20MANOR%20NURSING%20HOME>.

² Statement of Deficiencies for Good Samaritan Society – Albert Lea (Apr. 27, 2017), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=245441&SURVEYDATE=04/27/2017&INSPTYPE=STD>.

³ Statement of Deficiencies for Woodhaven Nursing Home (Nov. 6, 2019), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335514&SURVEYDATE=11/06/2019&INSPTYPE=STD&profTab=1&Distn=6672.7&state=NY&lat=0&lng=0&name=WOODHAVEN%20NURSING%20HOME>.

⁴ Statement of Deficiencies for Walker Rehabilitation Center, Inc. (Feb. 6, 2020), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=015408&SURVEYDATE=02/06/2020&INSPTYPE=STD&profTab=1&Distn=7595.6&state=AL&lat=0&lng=0&name=WALKER%20REHABILITATION%20CENTER%2C%20INC>. The resident's gender was not identified. To make the newsletter more reader-friendly, we identify the resident as male.